U.S. Department of Labor

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Issue Date: 26 October 2006

Case No.: 2005-BLA-05163

In the Matter of

H. S.
Claimant

v.

LEECO, INC.
Employer

and

TRANSCO ENERGY COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: MONICA RICE-SMITH, Esq.
For Claimant

JOHN H. BAIRD, Esq.
For Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On November 3, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, the case was assigned to me. The hearing was held before me in Hazard, Kentucky on June 21, 2006, at which time the parties had full opportunity to present evidence and argument. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.[1]

I. ISSUES

The following issues are presented for adjudication.[2]

(1) whether the Claimant has pneumoconiosis;
(2) whether his pneumoconiosis, if any, arose from coal mine employment;
(3) whether the Claimant is totally disabled;
(4) whether the Claimant's total disability, if any, is due to pneumoconiosis; and
(5) whether the Claimant has established a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d).

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on June 18, 2001 (DX 2).[3] On May 6, 2003, the District Director issued a proposed Decision and Order denying benefits to the Claimant (DX 26). The Claimant timely requested a formal hearing and, on August 15, 2003, the matter was referred to the Office of Administrative Law Judges (DX 33).

On June 16, 2004, Administrative Law Judge (ALJ) Rudolf L. Jansen, to whom this matter had been assigned, remanded the matter to the District Director (DX 34). Administrative Law Judge Jansen determined, based on the record, that the pulmonary evaluation provided to the Claimant in conjunction with the filing of his claim was not a "complete and credible evaluation sufficient to satisfy the Director's adjudicatory burden under § 725.406." Consequently, ALJ Jansen determined that the matter was "not ready for adjudication at a formal hearing" and returned the matter to the District Director, to "complete its evidentiary development responsibilities" (DX 34 at 73).

After the matter was remanded to the District Director, the District Director, in August 2004, contacted Dr. Glen Baker, the physician who had initially conducted the Claimant's pulmonary evaluation under § 725.406. The District Director requested that Dr. Baker provide the specific basis for his conclusion that the Claimant had pneumoconiosis (DX 34 at 2). Dr. Baker responded (DX 34 at 3), and the matter was thereupon returned to the Office of Administrative Law Judges (DX 35).

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[1] The Claimant's counsel waived submission of a post-hearing brief. See § 725.455(d).

[2] The parties stipulated that the Claimant has 35 years of coal mine employment (T. at 10). I find that the record supports this stipulation.

[3] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T" refers to the transcript of the June 21, 2006 hearing.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in June 1944 and is, therefore, 62 years old. He is married and has no dependents other than his wife (DX 2). The Claimant served in the United States Army between 1962 and 1964. Thereafter, beginning in late 1964, according to the evidence of record, which includes copies of the Claimant's Social Security Administration earnings and his W-2 forms, the Claimant was employed by various coal mine operators until 1999. In 1998 and 1999, the Claimant was employed by the Employer (DX 5, 6, 7).

In February 2000, the Claimant submitted a Claim for benefits under the Black Lung Act. However, in April 2001, after the claim had been referred to an Administrative Law Judge for hearing, the Claimant sought to withdraw it. On May 10, 2001, ALJ Daniel J. Rokentenetz approved the withdrawal, as authorized by § 725.306(b).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that the majority of his coal mine employment was in above ground mines. He worked as a heavy equipment operator, and ran end loaders, bulldozers, backhoes, and graders. Primarily, he ran an end loader, which was a machine that loaded coal into trucks (T. at 13). In general, the cabs of the machines were not enclosed, until the 1980s (T. at 14). Loading coal into trucks produced a great deal of dust (T. at 15).

The Claimant testified that he worked until December 1999, and stopped working because of a shoulder injury (T. at 15). His primary family physician, Dr. Sandlin, prescribes Albuterol and oxygen, and has referred him to another physician, Dr. Alam, for his breathing problems (T. at 16-17).

The Claimant testified that his breathing problems prevent him from hunting, because he can't walk the hills like he used to. He also is unable to mow the grass due to his breathing problems. He has a cough, which brings up phlegm, and his breathing affects his ability to sleep (T. at 18). The Claimant stated that he had been a smoker in the past, but it had been at least 10 years since he stopped smoking. He stated that he smoked for about 30 years, and averaged a pack to a pack and a half a day (T. at 19-21).

The record also contains the transcript of a deposition of the Claimant, conducted by the Employer in October 2001 (DX 18). In his deposition testimony, the Claimant stated that he had back problems, and that the shoulder he injured in 1999 was still giving him problems. He also testified that he had had breathing problems for about 15 years, and also had some high blood pressure. In his deposition, the Claimant stated that his job with the Employer involved heavy manual labor at times, for example if he had to assist with repairing the machinery.

c. Relevant Medical Evidence

In August 2001, Dr. Glen Baker performed the pulmonary evaluation pursuant to § 725.406, in conjunction with the Claimant's Claim, and rendered a written report (DX 11). In August 2004, after the matter was remanded back to the Director, in response to the Director's inquiry, Dr. Baker submitted additional information pertaining to the Claimant (DX 34). The Claimant presented a medical report from Dr. Raghu Sundaram, dated November 2002 (CX 1) and medical treatment records from Dr. Mahmood Alam, the Claimant's treating physician, covering the period from 2002 to 2005 (CX 2).

The Employer presented a medical report from Dr. David M. Rosenberg, dated March 2004, as well as a transcript of a June 2004 deposition of Dr. Rosenberg (DX 34). The Employer also presented a supplemental medical report from Dr. Rosenberg, dated May 2006 (EX 1). Additionally, the Employer submitted a medical report from Dr. Matthew Vuskovich (EX 2).

In addition to X-ray interpretations contained in Dr. Rosenberg's medical report, the Employer presented, in its affirmative case, an X-ray interpretation by Dr. Jerome Wiot of an X-ray administered in December 2001 to the Claimant (DX 25). The Employer also presented, in rebuttal, Dr. Wiot's interpretations of X-rays administered in August 2001 and September 2002 (DX 24; EX 4). In addition, the Employer proffered Dr. Wiot's interpretation of a CT scan administered to the Claimant in December 2001 (DX 25).

Although the Employer did not proffer a medical report from Dr. Bruce Broudy, the Employer did introduce results of pulmonary function and arterial blood gas tests that Dr. Broudy performed on the Claimant in December 2001 (EX 3). Lastly, the Employer submitted medical treatment records from Our Lady of the Way hospital, dating from September 2002 (EX 5).[4]

These items will be discussed in greater detail below.

D. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled: and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

[4] Employer's Exhibits 6-9 consist of the professional qualifications of Drs. Vuskovich, Broudy, Wiot, and Rosenberg, respectively.

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

A claim filed more than a year after the final denial of the Claimant's previous claim is considered a subsequent claim. A subsequent claim must be denied unless the Claimant can demonstrate that one or more applicable conditions of entitlement have changed since the final denial of the prior claim. § 725.309(d). Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004). However, § 725.306(b), which deals with withdrawals of claims, states: "When a claim has been withdrawn under paragraph (a) of this section, the claim will be considered not to have been filed."

The Claimant requested that his prior claim be withdrawn, and that withdrawal request was approved by ALJ Rokentenetz in 2001. There is no record of any other claim from the Claimant prior to the present claim. Based on § 725.306, therefore, I must consider that there is no prior claim from the Claimant. Consequently, § 725.309 does not apply in the instant matter.

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[5]

[5] These are as follows: (a) An irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where

(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. The latter section provides that ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[6]	Interpretation
08/30/2001	08/30/2001	DX 11	Baker	B reader	ILO: 1/0 (3 zones). P shape predominates
08/30/2001	03/14/2002	DX 24	Wiot	BCR, B reader	Negative
12/14/2001	03/01/2002	DX 25	Wiot	BCR, B reader	Neg. for pneumoconiosis; nodule noted ("not CWP")
09/16/2002	10/05/2002	CX 1	Sundaram	None	ILO:1 / 2 (4 zones). P shape predominates
09/16/2002	04/20/2006	EX 4	Wiot	BCR, B reader	Negative
02/17/2004	02/17/2004	DX 34	Rosenberg	B reader	ILO: 0/0. Possible Nodule Right upper lung (RUL)

In addition, the record contains records of other X-rays administered to the Claimant in the course of medical treatment (CX 3, EX 5). These also include CT scans of the Claimant's lungs (CX 3). Except for one X-ray, it is unclear whether these images were interpreted for pneumoconiosis.[7]

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the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[6] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[7] An additional interpretation of the Claimant's 9/16/2002 X-ray is also included at EX 5. Each party has proffered other interpretations of this X-ray. The interpretation in EX 5, admissible as

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988).

In this matter, all physicians, except Dr. Sundaram, are B readers. Consequently, because Dr. Sundaram lacks the professional qualifications of the other physicians, I give Dr. Sundaram's interpretation less weight. Dr. Baker and Dr. Rosenberg are B readers, but are not Board-certified radiologists. Because of their professional expertise in interpreting X-rays, I give their interpretations some weight. However, I give more weight to the interpretations of Dr. Wiot, because he is dually qualified, as a Board-certified radiologist and a B reader. Dr. Wiot's professional training, as a Board-certified radiologist, gives him the broadest experience, of all the physicians here, in interpreting X-rays. Moreover, as a Board-certified radiologist, Dr. Wiot is expected to have experience in interpreting chest X-rays for conditions other than pneumoconiosis.

Based on the foregoing, the weight of the X-ray evidence does not establish that the Claimant has pneumoconiosis. The only physicians to interpret an X-ray as positive for pneumoconiosis are Dr. Sundaram and Dr. Baker. Neither is a Board-certified radiologist, and only Dr. Baker is a B reader. On the other hand, another physician who is a B reader, Dr. Rosenberg, and a dually certified physician, Dr. Wiot, both have interpreted the Claimant's X-rays as negative for pneumoconiosis. Notably, Dr. Wiot has interpreted as negative the very same X-rays that Dr. Sundaram and Dr. Baker have interpreted as positive.

Based on the foregoing, I find that the Claimant is unable to establish by a preponderance of evidence that he has pneumoconiosis based on X-ray interpretations.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray,

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a medical treatment record under § 725.414(a)(4), is in narrative format and is from a physician with unknown professional credentials. Consequently, I give little weight to this interpretation.

biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

As stated above, the definition in § 718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis, which are defined, respectively, in § 718.202(a)(1) and (2). Under these definitions, legal pneumoconiosis includes any chronic lung disease or its sequelae arising out of coal mine employment. This includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease, when causally related to coal mine employment.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

Dr. Glen Baker (DX 11, 34; CX 3)

As noted above, Dr. Baker conducted the pulmonary evaluation on behalf of the Department of Labor, in conjunction with the Claimant's claim. See § 725.406. Dr. Baker, who is Board-certified in internal medicine and pulmonary disease and is a B reader, examined the Claimant, took a medical and work history, administered a chest X-ray, pulmonary function tests, and arterial blood gas tests, and submitted a written report.[8] In his report, Dr. Baker assessed the Claimant based on the Claimant's reported 37 years of surface mining and a smoking history of up to 120 pack-years (3 packs per day for 40 years, 1958 to 1998). The report did not reflect any negative physical findings (such as wheezing, rales, etc.) Dr Baker diagnosed the Claimant with coal workers' pneumoconiosis based on abnormal X-ray (ILO: 1/0)

[8] I note that one page of DX 11 consists of a medical assessment from Dr. Baker, but it pertains to a different individual, not the Claimant. I disregarded that page.

and coal dust exposure; chronic bronchitis based on history of cough, sputum production, and wheezing; and hypoxemia based on blood oxygen level (in arterial blood gas testing). Dr. Baker's report assessed the cause of the Claimant's coal workers' pneumoconiosis as coal dust exposure, and the cause of the other two diagnosed ailments as "coal dust exposure/cigarette smoking."

This matter was remanded to the District Director based on ALJ Jansen's determination that Dr. Baker's report was insufficient. In his Remand Order, ALJ Jansen noted that "a diagnosis of pneumoconiosis based on a positive chest X-ray and history of dust exposure alone is not a well documented and reasoned opinion" (DX 34 at 73). As noted above, after the matter was remanded, the District Director contacted Dr. Baker for additional comments. Dr. Baker responded that his diagnosis of coal workers' pneumoconiosis was based on the X-ray and history of coal dust exposure "as well as the exclusion of any other disease that could cause similar changes. The Miner has no other significant diseases that could cause X-ray changes consistent with Coal Workers Pneumoconiosis" (DX 34 at 3). Additionally, Dr. Baker stated that the Claimant has legal pneumoconiosis. According to Dr. Baker, the Claimant has minimal bronchitis which "has been significantly contributed and substantially aggravated by coal dust exposure."

Dr. Raghu Sundaram (CX 1)

The Claimant submitted a written medical report from Dr. Raghu Sundaram, dated November 2002. Dr. Sundaram's medical qualifications are not a matter of record. Dr. Sundaram is a treating physician who has treated the Claimant since August 2002. For purposes of this report, Dr. Sundaram examined the Claimant, took a medical history, and administered a chest X-ray, pulmonary function tests, and arterial blood gas tests. Dr. Sundaram's written report assessed the Claimant in light of a coal mine employment history of over 35 years and a smoking history of 1 ½ packs per day, ending six years before.

Dr. Sundaram diagnosed the Claimant with "clinical pneumoconiosis" and "legal pneumoconiosis" and stated that the basis of his diagnosis was "35 years of exposure to coal dust." Dr. Sundaram concluded that the Claimant's condition was significantly contributed to, or substantially aggravated by, dust exposure in coal mine employment, and stated it was difficult to separate the impairment due to coal dust from impairment due to smoking (CX 1).

Dr. David Rosenberg (DX 34; EX 1, 9)

The Employer submitted a medical report from Dr. David Rosenberg, dated March 2004, as well as a transcript of Dr. Rosenberg's deposition testimony, from June 2004. Dr. Rosenberg is Board-certified in internal medicine, pulmonary disease, and occupational medicine, and is a B reader. In addition to his medical degree, Dr. Rosenberg has a masters degree in public health (M.P.H.)(EX 9).

Dr. Rosenberg conducted a physical examination of the Claimant, took a medical and work history, and administered a chest X-ray, pulmonary function test, and arterial blood gas tests. It does not appear that Dr. Rosenberg reviewed any medical test results or reports

generated by others. In his medical report, Dr. Rosenberg based his conclusions on a reported coal mine employment of 37 years, and presumed that the Claimant's last coal mine job, as a heavy equipment operator, required a moderate degree of manual labor (lifting 20 to 30 pounds on an occasional basis). Dr. Rosenberg also presumed a smoking history of more than 30 years, at the rate of one to two packs a day, ending in 1996.

Dr. Rosenberg concluded, based upon the Claimant's lung function tests, physical examination, and X-ray, that the Claimant did not have the interstitial form of coal workers' pneumoconiosis.[9] He had no significant restriction or obstruction, his diffusing capacity was intact, and his blood oxygenation was only mildly impaired.[10] Consequently, the Claimant did not have chronic obstructive lung disease (EX 34).

In June 2004, Dr. Rosenberg testified by deposition. In his deposition testimony, he reiterated the findings recorded in his written report, and he clarified that he saw no connection between coal dust exposure and the nodule that he had observed in the Claimant's lung (DX 34).

The Employer also submitted an addendum from Dr. Rosenberg, dated March 2006, which supplemented his initial report. In this addendum Dr. Rosenberg discussed his review of medical records pertaining to the Caimant, which consisted of records from the Mountain Comprehensive Health Corporation, the MCHC lung clinic, and Dr. Alam's records. Dr. Rosenberg summarized the records as reflecting the Claimant's positive skin test for tuberculosis; the records also reflected that the nodule in the Claimant's lung was evaluated and determined to be stable. Dr. Rosenberg concluded that the nodule on the Claimant's lung does not represent coal workers' pneumoconiosis, and undoubtedly relates to old granulomatous disease, in view of the Claimant's positive skin test for tuberculosis and family history of exposure. Dr. Rosenberg noted that the Claimant's lung functions were essentially normal. Consequently, Dr. Rosenberg concluded, the Claimant does not have either "medical or legal CWP" (EX 1).

Dr. Matthew Vuskovich (EX 2, 6)

The Employer submitted a medical report from Dr. Matthew Vuskovich, dated May 2006. Dr. Vuskovich is Board-certified in occupational medicine and is a B reader (CX 6). In addition to his medical degree, Dr. Vuskovich also holds a masters degree in Environmental and Occupational Health. His report is based on a review of medical records (including results of medical tests) pertaining to the Claimant covering the time period from 2001 to 2004. In making his assessment, Dr. Vuskovich presumed the Claimant had 35 years of coal mine employment in surface mines as a heavy equipment operator and 36 years of smoking at a rate of 1 ½ packs per day. Additionally, Dr. Vuskovich presumed that the Claimant had been exposed to tuberculosis.

Dr. Vuskovich concluded that the Claimant did not have clinical coal workers' pneumoconiosis. Based on the medical test results, the Claimant also did not have any

[9] Dr. Rosenberg noted a nodule on the Claimant's lung; his report stated that the Claimant should be referred for further analysis of the nodule.

[10] Dr. Rosenberg noted that the Claimant was using oxygen at night.

pulmonary impairment. Dr. Vuskovich opined that the nodule in the Claimant's lung, which was noted to be stable, was most likely a latent tuberculosis infection, based on the Claimant's family history of exposure. According to Dr. Vuskovich, this latent infection was unrelated to the Claimant's coal mine employment (EX 2).

Additional Medical treatment records

The Claimant submitted 37 pages of medical treatment records from Dr. Mahmood Alam (CX 2). Dr. Alam's medical credentials are not a matter of record. Dr. Alam's treatment records, dating primarily from 2004 and 2005, include records of medical testing (including chest X-rays, a pulmonary function test and an arterial blood gas test) as well as treatment notes. The treatment notes reflect that the Claimant was referred to Dr. Alam for evaluation of a small pulmonary nodule in August 2004. The notes reflect that the Claimant had a history of tuberculosis exposure (a family member had tuberculcosis); more than 35 years of coal mine employment, and a 30-year smoking history, ending in 1996. The treatment notes indicate that the nodule remained stable; Dr. Alam assessed that the Claimant had chronic obstructive pulmonary disease (COPD) and coal workers' pneumoconiosis (CWP), but the basis for these conclusions is not given. The records reflect that over the course of Dr. Alam's treatment, the Claimant reported increased shortness of breath (dyspnea), and Dr. Alam suspected cardiovascular disease, but test results were within normal limits.

The Employer submitted two pages of medical treatment records from Our Lady of the Way hospital. These records consist of narrative X-ray reports dating from September 2002 (EX 5).

Discussion

In this matter, Dr. Baker and Dr. Sundaram have concluded that the Claimant has both clinical and legal pneumoconiosis. Dr. Rosenberg and Dr. Vuskovich, on the other hand, have concluded that he has neither. Dr. Alam's treatment records reflect his conclusions that the Claimant may have both clinical pneumoconiosis and chronic obstructive pulmonary disease.

Dr. Alam's treatment records (CX 2) are of little value in assessing whether the Claimant has pneumoconiosis, and consequently, I assign them little weight. I understand, however, that these are not diagnostic records, and so their purpose is not to determine the Claimant's condition, but to treat his ailments.

I find Dr. Sundaram's opinions not to be well-reasoned and I assign them minimal weight. First, he gives no explanation whatsoever for his diagnoses other than the statement "35 years of exposure to coal dust." As the regulation makes clear in § 718.201(a)(4), a diagnosis must be made on the basis of objective medical tests. A diagnosis of pneumoconiosis based solely on a history of coal dust exposure, therefore, is totally inadequate.

Second, although Dr. Sundaram states that the Claimant's conditions have been contributed to or aggravated by dust exposure in coal mine employment, he does not explain how the Claimant's ailments have been so impacted. Although Dr. Sundaram acknowledges that the

Claimant's smoking history has an effect on his condition, he states only that it is "difficult to separate impairment from coal dust vs smoking." Because Dr. Sundaram does not articulate how the Claimant's condition has been influenced by dust exposure, but merely states this conclusion, I am unable to assess how Dr. Sundaram arrived at the conclusion, or what evidence points to his determination. Therefore, I give little weight to Dr. Sundaram's determination that the Claimant has "legal" pneumoconiosis.

Dr. Baker's determination that the Claimant has clinical pneumoconiosis is based on three factors: X-ray interpretation (his own); the Claimant's coal mine employment history; and the lack of any other causative element to explain the X-rays. Dr. Baker has significant professional expertise, being Board-certified in pulmonary medicine and a B reader. However, as he himself states, the most significant factor in his determination that the Claimant has clinical pneumoconiosis is the X-ray. And, as noted earlier, another physician with superior radiological credentials has interpreted the very same X-ray that Dr. Baker relied upon, and found no evidence of pneumoconiosis. In fact, there may be no other objective evidence for Dr. Baker to cite, for he acknowledged that the Claimant has only a mild pulmonary impairment, and the results of the Claimant's physical examination were essentially normal. Because Dr. Baker's determination as to clinical pneumoconiosis is based primarily on disputed X-ray evidence, I give his opinion little weight.

I find Dr. Baker's determination that the Claimant has chronic bronchitis, and that the Claimant's bronchitis is related to his coal dust exposure, not to be well-reasoned. Accordingly, I give it little weight. I infer, based on Dr. Baker's initial written report, that Dr. Baker's conclusion was based on the Claimant's reported history, and not on physical examination, which was basically normal. Dr. Baker's written report does not note any wheezing, coughing, or other objective physical manifestations of bronchitis. Moreover, as noted above, the Claimant did not demonstrate a respiratory impairment (except for a mild resting hypoxemia, which is not disabling). Dr. Baker has stated, both in his initial written report and in his later report to the District Director, that coal dust exposure contributed to this condition. However, in both reports, Dr. Baker's statement is conclusory; he does not state how significant a factor the Claimant's dust exposure was, nor does he point to any specific physical symptom or impairment that is related to dust exposure rather than smoking. The definition of "legal pneumoconiosis" in § 718.201(a)(2) is "any chronic lung disease or impairment." I find the evidence in Dr. Baker's reports insufficient to establish that the Claimant has a chronic lung disease, because Dr. Baker did not report any physical manifestations of disease.

As noted above, Dr. Baker reported only a mild impairment and reported a mild resting hypoxemia. Further, he stated that this hypoxemic condition was due to dust exposure and smoking. Although Dr. Baker's statement is not entirely clear, I infer that Dr. Baker has concluded that the Claimant is mildly impaired based on the hypoxemia. However, because Dr. Baker's statement that the Claimant's condition is due to dust exposure and smoking is conclusory, and does not indicate how great a role each factor played in the Claimant's impairment, I am unable to conclude that the Claimant's hypoxemia was significantly related to, or substantially aggravated by, dust exposure. Consequently, I do not find that the Claimant's mild resting hypoxemia, as described by Dr. Baker, constitutes pneumoconiosis, as defined in § 718.201.

I find Dr. Rosenberg's conclusion, that the Claimant does not have clinical pneumoconiosis or any other dust-related illness, to be well-reasoned, and I give it substantial weight. Dr. Rosenberg is Board-certified in occupational medicine as well as pulmonary disease. Therefore, he has the professional qualifications to assess the relationship between occupational dust exposure and pulmonary disease and, as he testified in his deposition, he has wide experience in that area. Dr. Rosenberg's conclusion that the Claimant does not have coal worker's pneumoconiosis is based on a multitude of factors, including negative X-ray, lack of physical symptoms, and lung function test scores demonstrating neither restrictive nor obstructive disease. Although Dr. Rosenberg did not mention "legal pneumoconiosis" directly, he did determine that the Claimant did not have chronic obstructive pulmonary disease, and he noted that the Claimant's blood oxygenation was only mildly reduced. Consequently, I find that Dr. Rosenberg determined that the Claimant did not have any form of pneumoconiosis, as defined in § 718.201.

I find Dr. Vuskovich's conclusion, which is that the Claimant has neither clinical pneumoconiosis nor any other dust-related impairment, to be of some value, although not as much value as Dr. Rosenberg. Consequently, I assign it some weight. Dr. Vuskovich is Board-certified in occupational medicine, though not pulmonary medicine. His report was based on his review of medical reports and records relating to the Claimant. He did not examine the Claimant and, consequently, was unable to draw any conclusion based on physical examination. I find Dr. Vuskovich's conclusion, that the nodule on the Claimant's lung is most likely related to tuberculosis, to be supported by evidence. Although it is not necessary for me to make any finding of fact relating to this artifact, I do find that there is no evidence that the Claimant's lung nodule is causing any pulmonary impairment.

Based on the foregoing, and considering all the evidence set forth above, including the X-ray evidence, I find that the Claimant is unable to establish, by a preponderance of evidence, that he has clinical pneumoconiosis or any form of pneumoconiosis, as defined in § 718.201.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). The parties have stipulated that Claimant has established a coal mine employment history of 35 years, and therefore, is entitled to the rebuttable presumption.

However, as set forth above, I have found that the Claimant is unable to establish that he has pneumoconiosis, as regulatorily defined in § 718.201. Consequently, he is unable to benefit from this presumption.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally

disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from engaging in gainful employment … requiring the skills and abilities comparable to those of any employment in a mine or mine in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danro Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the following pulmonary function test results (where two values are given, the second value represents measurements taken after bronchodilator medication was administered):

Date of Test	Physician	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
08/30/2001	Baker	3.28	4.11	111	80%	Yes
12/14/2001	Broudy	3.23	3.91	91	83%	Yes
11/11/2002	Sundaram	3.38	4.08	unk	83%	Yes
02/17/2004	Rosenberg	3.10	3.75	44	83%	Yes
08/25/2004	Alam	3.36/3.53	3.97/4.22	78/unk	85%/84%	No[11]

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test, and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

[11] This pulmonary function test was administered for medical treatment purposes and consists of single trials (one trial before bronchodilation and one trial after bronchodilation).

The Claimant was born in June 1944 and therefore, was 57 to 60 years old at the time these pulmonary function tests were administered. His height was variously recorded at 70 and 71 inches, but was most often recorded at 70 inches (4 of 5 tests). Presuming that the Claimant is 70 inches tall, the qualifying FEV_1 values are 2.08 at age 57, 2.06 at age 58, 2.04 at age 59, and 2.03 at age 60. The Claimant's scores for all pulmonary function tests exceeded these qualifying values.

I find that, based on the foregoing test results, the Claimant is unable to establish that he is totally disabled.

Arterial Blood Gas Test Results

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)
8/30/2001	Baker	44	74	None [12]	None
12/14/2001	Broudy	42.6	69.1	None	None
11/11/2002	Sundaram	41	85	None	None
2/17/2004	Rosenberg	43.1	79.3	None	None
8/25/2004	Alam	42.4	84.7	None	None

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The test that Dr. Baker administered was conducted at an altitude of less than 2999 feet, in Corbin, Kentucky. The altitudes at which the other tests were conducted are not recorded, but I presume that these tests were done at altitudes of less than 5999 feet. As shown in the table above, the Claimant's PCO_2 values were consistently between 41 and 45. At an altitude below 2999 feet, the qualifying PO_2 value based on a PCO_2 value between 40 and 49 is 60 or less. At an altitude between 3000 and 5999 feet, the qualifying PO_2 value based on a PCO_2 value between 40 and 49 is 55.

[12] The record indicates that an exercise test was not administered due to degenerative joint disease ("DJD"). An exercise blood gas test shall be offered unless medically contraindicated. § 718.105(b). Under the circumstances described in the record, where the Claimant had medical conditions of a non-pulmonary nature that made exercise difficult, I find that an exercise blood gas test was contraindicated.

Based on the foregoing, therefore, I find that the Claimant is unable to establish, by means of arterial blood gas test, that he is totally disabled.

Cor pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). As stated above, I have found that the Claimant had not established the existence of pneumoconiosis. Moreover, there is no evidence of cor pulmonale with right sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989).

Dr. Baker opined that, based on the pulmonary function test results, the Claimant had mild pulmonary impairment, and retained the pulmonary capacity to do the work of a coal miner (DX 11; DX 34).[13] Dr. Sundaram concluded that the Claimant was severely impaired, and did not have the respiratory capacity to perform as a coal miner. Dr. Sundaram based his conclusion on the fact that the Claimant had shortness of breath with limited activity. In his written report and deposition, Dr. Rosenberg concluded that, based on the Claimant's normal or near-normal lung function, he was not disabled, and could perform his previous coal mine employment as a heavy equipment operator (DX 34). Later, in the addendum to his written report, Dr. Rosenberg reiterated the same conclusion: that the Claimant does not have any significant pulmonary impairment (EX 1). Dr. Vuskovich did not render an opinion regarding whether the Claimant was disabled from coal mine employment. He did, however, state that the Claimant did not have any pulmonary impairment (EX 2).

The weight of the physician opinion evidence is that the Claimant is not totally disabled, as defined in the regulation. Three of the four physicians who rendered opinions stated that the Claimant remained physically able to perform his last coal mine employment. The only exception is Dr. Sundaram, who concluded that the Claimant was severely impaired and lacked

[13] In his initial written report, Dr. Baker indicated that the Claimant had a mild impairment, but was able to work in coal mine employment; in his later report to the District Director Dr. Baker stated that the Claimant had no significant impairment.

the respiratory capacity to continue in his past employment, because of the Claimant's shortness of breath upon limited activity. It is not clear, however, from the evidence of record, whether Dr. Sundaram had a full knowledge of the nature of the Claimant's coal mine employment; in the form Dr. Sundaram used, the section summarizing the Claimant's coal mine employment history is blank. The record does not reflect whether Dr. Sundaram examined other records (for example, the Claimant's claim) or otherwise had a basis of knowledge regarding the Claimant's coal mine employment.

It is well settled that a reasoned opinion regarding total disability must be based on informed knowledge of the nature of the physical demands of the employment. See Brigance v. Peabody Coal Co., BRB 05-0722 BLA (June 29, 2006)(en banc). Where, as here, the record does not establish whether a physician understood the physical rigor of the Claimant's coal mine employment or took the exertional demands of that employment into consideration, that physician's opinion is not well-reasoned. Consequently, because it is not well-reasoned, I give Dr. Sundaram's opinion little weight.

Based on the evidence set forth above, including evidence of pulmonary function and arterial blood gas tests, none of which produced results indicating that the Claimant is totally disabled, I find that the Claimant is unable to establish, by a preponderance of evidence, that he is totally disabled, as required by § 718.204.

d. Whether the Claimant's disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Lollar v. Alabama By-Products Corp., 893 F.2d 1258, 1265 (11th Cir. 1990); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

As noted above, I have found that the Claimant is unable to establish, by a preponderance of evidence, that he is totally disabled. Consequently, I find that he is likewise unable to establish, by a preponderance of evidence, that he is totally disabled due to pneumoconiosis.

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has not established his entitlement to benefits under the Act.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. Because benefits were not awarded in this Claim, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the Claim.

VI. ORDER

The Claimant's Claim for benefits under the Act is DENIED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).